MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Advanced Practice, Inc. on behalf of Baylor Medical Center at Irving 17101 Preston Road, Suite 180-S Dallas, Texas 75248-1331	MDR Tracking No.: M4-04-3548-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Casualty Company of Reading PA C/O Stone, Loughlin & Swanson, LLP P O Box 30111 Austin, Texas 78755 Box 06	Date of Injury: Employer's Name: Manpower, Inc. a Wisconsin Corporation Insurance Carrier's No.: 3A808945

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/17/03	**01/27/03**	**Surgical Admission**	**$39,143.05**	**$17,530.00**

PART III: REQUESTOR'S POSITION SUMMARY

"We are aware of recent SOAH Hearing determinations to allow carving out implant charges to then determine the stoploss threshold, however feel this is not in line with the TWCC Guidelines, nor feel that this method has been established as 'fair and Reasonable' reimbursement for the implants or a Stoploss admission over $40,000. We have done further research of other States Worker's Compensation Regulations and Managed Care contracts and have supporting evidence that supports a transition to payment based on a percent of billed charges once Stoploss threshold has been met; and supports Implants are not routinely paid at a Cost plus 10% methodology, in either a per diem based reimbursement, or especially when the claim meets a set stoploss threshold amount."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by the provider, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that additional reimbursement is due for these services.

The total length of stay for this admission was 10 days (10 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $11,180.00(10 times $1,118.00). In addition, the hospital is entitled to additional reimbursement for (implantables

and 10 day hospital stay) as follows:

Carrier's reimbursement of the ten day admission is $6,960.00

The carrier did not reimburse the provider per rule 134.401(c)(2) for the inpatient admission amount of $11,180.00(10 days x $1,118.00) - $6,960.00 already paid, leaving $4,220.00 in additional reimbursement for per diem.

Provider charged $22,069.00 per the UB-92 for the implantables.

Implantables: Invoice totals submitted by provider = $12,100.00

Carrier reimbursement of implantables was $0.00

The implantables were not properly reimbursed per rule 134.401(c)(4)(A) at cost plus 10%. Invoice total is $12,100.00 x 10% = $13,310.00 - $0.00 already paid = $13,310.00 additional reimbursement for the implantables.

The amount of additional reimbursement recommended is $13,310.00 for the implantables + $4,220.00 for the ten day inpatient admission = $17,530.00 additional reimbursement.

Therefore, based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health care provider is entitled to an additional reimbursement amount for these services equal to $17,530.00.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$17,530.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Allen McDonald	03/04/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____